UNIVERSITY OF ARKANSAS

Division of Student Affairs
Center for Educational Access

Authorization to Release/Obtain Confidential Information

NAME _____ **DATE** _____

DATE OF BIRTH_____ **STUDENT ID #** _____

☐ **I hereby authorize the Center for Educational Access to release confidential educational information and/or other records to:**

_____

_____

_____

☐ **I hereby authorize the University of Arkansas Center for Educational Access to obtain confidential information and/or other records including medical and/or psychological testing, evaluation and treatment concerning the above named individual from:**

_____

_____

_____

This authorization expires 60 days from the date it is signed. I understand that I may revoke this authorization, in writing, at any time prior to the release of the information specified above.

_____ _____

Signature **Date** **Witness** **Date**

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